Child Fatality/Near Fatality County Webinar

Presented by the Children's Services Operation Bureau

November 15, 2017

HOUSEKEEPING

- All participants are on mute and will be unmuted periodically to provide feedback
- Do not use the HOLD BUTTON
- To enable the speaking option, please enter your Audio PIN after entering the Access Code.
- Feel free to use the chat feature to ask questions during the webinar.
  - Common questions will be answered verbally
  - Any unanswered questions will be responded to after the webinar via email
- When speaking, please state your name and county/agency

WEBINAR OUTLINE

Section 1: Description and Recruitment of Citizen Review Panel

Section 2: Reporting Requirements

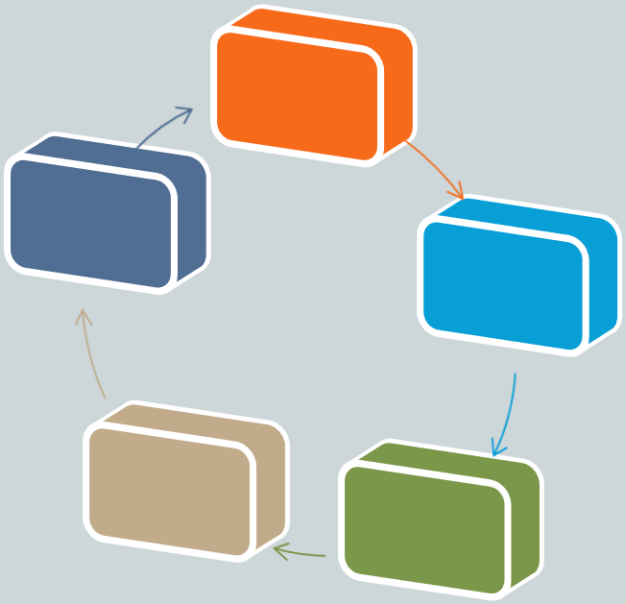
Section 3: Best Reporting Practices by County CWS Agencies

Section 4: August 2017 Webinar Poll Follow-up

Collaborative Engagement

- Community Partners -

The overarching purpose of this Webinar is to connect inter-agencies who report or review child fatalities & near fatalities to facilitate conversations to enhance collective efforts toward strengthening critical incident prevention efforts.



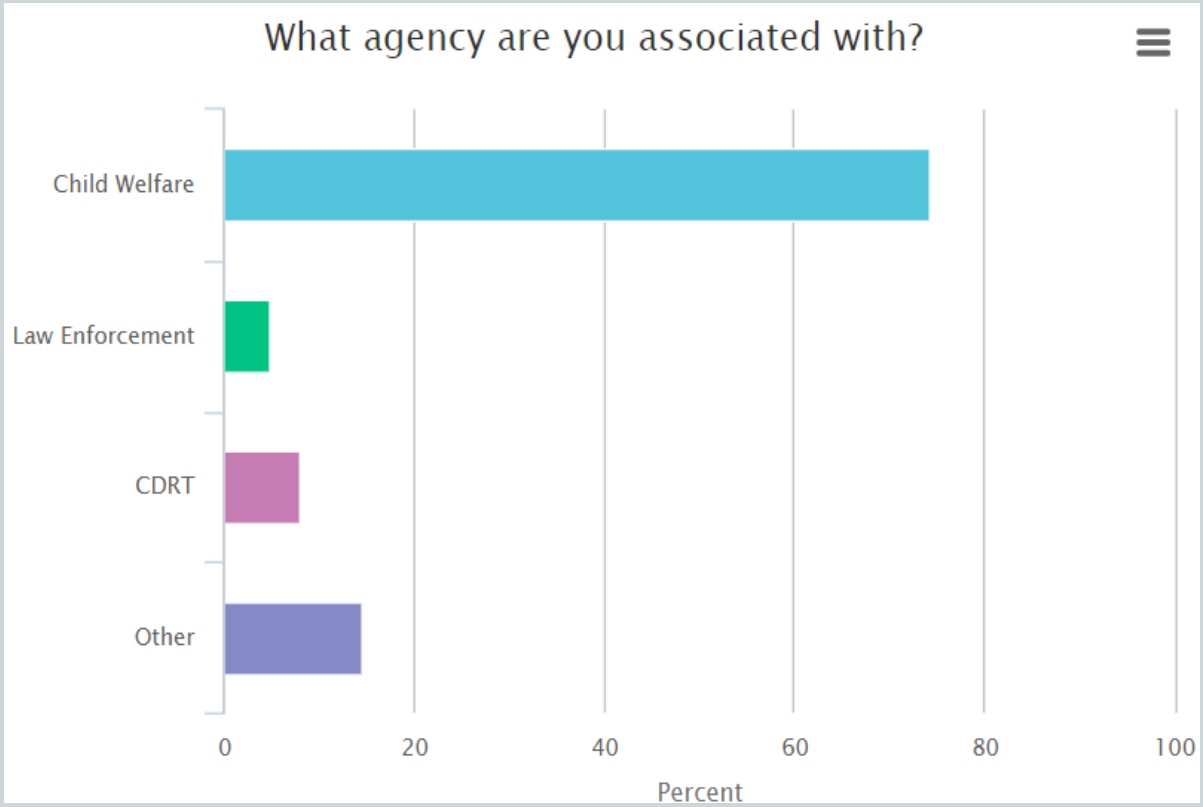
POLL QUESTION:

- Which agency are you associated with?
  - Child Welfare
  - Law Enforcement
  - Coroner
  - CDRT
  - Other

NOTES FROM WEBINAR: POLL QUESTION RESPONSES

86% of participants responded:

- Child Welfare: 74%
- Law Enforcement 5%
- CDRT 8%
- Other 15%
- Coroner 0%



Section 1

Description and Recruitment of Citizen Review Panel

CITIZEN REVIEW PANELS

- Child Abuse Prevention and Treatment Act (CAPTA) requires Citizen Review Panels (CRPs)
- “Examine the policies, procedures and practices of state and local child protective service agencies and evaluate the extent to which agencies are effectively discharging their responsibilities”
- CRP members: former recipients of social services, foster parents, child welfare services professionals, court-appointed special advocates, children’s attorneys, educators, representatives of tribal governments and county public health and mental health agency staff, law enforcement officials, and other interested parties.

CITIZEN REVIEW PANELS

OCAP's vision:

- Three CRPs
  - Prevention and Early Intervention
  - Children and Family Services
  - Critical Incidents
- Annual consolidated report
- Application process, term-limits, by-laws, no "chair"

CITIZEN REVIEW PANELS

Contractor: “Big Picture Research and Consulting” 2017-2019

- Jesse Russell – National Council on Crime and Delinquency and National Council of Juvenile and Family Court Judges
- Developing application process, by-laws, identifying applicants
- CRP’s will be data-informed
- Contractor will facilitate meetings and provide research/data to the panels

CITIZEN REVIEW PANELS

If interested, contact Alexandria Michaud

Alexandria.Michaud@dss.ca.gov

NOTES FROM WEBINAR: CITIZEN REVIEW PANELS (CRPS)

- Marja Sainio – Manager from the Office of Child Abuse Prevention (OCAP) presented
- Discussed the importance of maintaining a minimum of 3 Citizen Review Panels.
- CRPs meet quarterly to review, analyze and make recommendations regarding services provided by state & local child protective agencies
- Historically 2 counties (Ventura & San Mateo) maintained CRPs & provided annual recommendations regarding local services through a report.
- New Vision includes having 3 statewide CRPs overseen by the CDSS that creates 1 robust annual report
- New Contractor that will assist in the facilitation of the CRP meetings & ensure a data driven purpose
- If interested in the Critical Incident CRP or any of the other CRPs, please contact Alexandria Michaud (*contact information on the previous slide*)

Section 2

Reporting Requirements

CHILD FATALITIES & NEAR FATALITIES REPORTING REQUIREMENTS

Child abuse investigations require a multi-disciplinary approach, with each agency maintaining its own purpose, methods, and goals for intervention.

Law Enforcement's focus:

- Investigate crimes and refer those believed to be responsible for the crime for criminal prosecution.

Child Welfare Agencies' focus:

- Protecting children from further abuse and neglect and maintaining the integrity of the family.

At times, these goals can appear to conflict, but it is essential that agencies work together to minimize unnecessary duplication of efforts while conducting a thorough investigation that'll result in the optimal response for the child and family.

CHILD FATALITIES & NEAR FATALITIES REPORTING REQUIREMENTS CONT.

WIC - 10850.4 & WIC - 10850.45

- Each county welfare department/agency is responsible for submitting the SOC 826 form with all relevant information on the form to the CDSS in all cases where a fatality or near fatality has been determined to be the result of abuse and/or neglect **within ten business days of determination.**

- **Determination:** Abuse and/or neglect is determined to have led to a child's death or near fatality if one or more of the following conditions are met:
  1. A county child protective services agency determines that the abuse and/or neglect was substantiated.
  2. A law enforcement investigation concludes that abuse and/or neglect occurred.
  3. A coroner or medical examiner concludes that the child who died had suffered abuse or neglect.

CHILD FATALITIES & NEAR FATALITIES REPORTING REQUIREMENTS CONT.

For reporting and disclosure purposes, child welfare shall rely on a determination by a law enforcement agency, coroner/medical examiner that abuse and/or neglect resulted in a child fatality or near fatality or that a child welfare agency has substantiated that abuse and/or neglect resulted in a child fatality/near fatality.

In some cases, law enforcement, coroner/medical examiner and/or CWS may reach differing conclusions when determining the cause of a child fatality/near fatality.

As long as one of the three agencies determine or substantiate abuse and/or neglect as a cause of or a material contributing factor to a child's fatality/near fatality, the county child welfare agency shall report and disclose pursuant to MPP Section 31-502.2 and section 31-502.3.

IMPORTANCE OF CROSS-REPORTING

When a fatality/near fatality (due to abuse/neglect) is not cross-reported across agencies

CW is not able to evaluate the family's needs/services or assess for risk & safety

CW is unable to evaluate whether the fatality/near fatality meets reporting requirements to CDSS Per SB 39 & AB 16-109

If a fatality/near fatality is not reported to CDSS, CDSS will not receive accurate information for preventative measures

For best practice purposes, it is important to cross-report even when:

- The perpetrator no longer has access to the child/children
- There are no other children in the home
- The perpetrator is not a caregiver/parent/household member

For more information, please see MPP 31-502.3

RESOURCES FOR REPORTING REQUIREMENTS

Resources for Reporting Requirements:

- ACL 15-81
- ACL 08-13
- ACL 16-109

- Other ACLs regarding Child Fatalities and Near Fatalities can be found at http://www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality/SB-39-and-ACLs

NOTES FROM WEBINAR: REPORTING REQUIREMENTS

- Hnu Xiong – Analyst from the Critical Incident Oversight & Support unit presented
- Welfare & Institutions Codes 10850.4 & 10850.45 are foundational in the identification of child fatality/near fatality reporting & disclosure
- Identified determining agencies: CWS, Law Enforcement &/or Coroner/Medical Examiner
- In some cases the 3 determining agencies may reach differing conclusions, if one of the three agencies determines/substantiates abuse &/or neglect contributed to the fatality/near fatality – the incident is reportable to the CDSS
- Cross-reporting and relationship building between community agencies/partners is crucial

SECTION 2
WEBINAR QUESTIONS & ANSWERS

- Q1: If the coroner is reporting there was a child fatality through CWS central intake hotline and CWS investigates, should we be reporting these to the state?
- A: It would be reportable to the CDSS if abuse &/or neglect was a contributing factor to the child fatality.
- Q2: What if the Coroner calls in a child fatality through CWS central intake hotline but they haven't conducted a complete autopsy, Law Enforcement conducts their own investigation and makes a determination, CWS does not conduct an investigation then the coroner says later that abuse &/or neglect was a factor. How would CWS know to report these types of incidents to the CDSS if we don't currently have an open referral/case on the family?
- A: These types of situations highlight the importance of collaboration amongst determining agencies for child fatalities/near fatalities. When the coroner makes the determination that abuse &/or neglect was a contributing factor in the fatality, best practices urge CWS to follow-up with the Coroner or vice versa to ensure that information is captured and assessed appropriately. The incident becomes reportable as soon as CWS learns of the determination that abuse &/or neglect was a contributing factor in the fatality.
- Q3: If the perpetrator no longer has access to the child, should agencies be cross reporting?
- A: Best practices highlight the importance of cross reporting in these situations. Although there may no longer be risk in the home in the perpetrators absence, it is important to capture the information for potential subsequent reports regarding the perpetrator. It is also important for CWS to investigate to identify if services are needed for the family & child. Also an investigation will determine if abuse substantiations need to occur so that appropriate parties are reported to CACI. We will discuss CACI in more detail later in the presentation.
- Q4: Will the webinar Power Point be made available following the webinar?
- A: Yes, the CDSS will post the materials to the CDSS – Critical Incident Oversight & Support unit webpage.

Section 3

Best Reporting Practices by County CWS Agencies

COLLABORATION AMONG AGENCIES

CHILD WELFARE · LAW ENFORCEMENT · CORONER · CDRT

BEST PRACTICE REPORT OUT

The following counties will be reporting out:

- **Orange County**
- **Los Angeles County**
- **Riverside County**

COUNTY OF RIVERSIDE
CALIFORNIA

CHILDREN'S SERVICES

Critical Incident
Child Fatality/Near Fatality Practices

RIVERSIDE COUNTY DEMOGRAPHICS

- As of 2015, Riverside County total population is 2.36 million. We are the 4th most populous County in State and 10th in the Nation.
- Riverside County's geographical area is huge, covering 7,303 square miles.
- Children's Services Division works with 28 cities, 23 school districts, 29 law enforcement agencies, and 12 Federally recognized tribes.
- 25% of the children in Riverside County live in poverty.
- Children's Services Division employs 1049 personnel to provide services to families in Riverside County.

CONTINUOUS QUALITY IMPROVEMENT

The Continuous Quality Improvement Unit is driven by two visions:

- We are building a strength-based, engaged workforce through leadership training.
- We are creating a culture of learning that includes a 360 degree examination of our processes and practices that continuously provides our unit with feedback as to what is working well, what concerns us, and what needs to be changed.

CRITICAL INCIDENTS

Riverside County Central Intake Center receives referrals for **all** child fatalities and near fatalities and will assess whether these referrals require an immediate response (24 hour), 10 day response, or will be evaluated out for another agency to respond.

These referrals are given a “critical incident” special project code, which requires staff to follow specific protocol and continuous staffing's between social workers, supervisors, and managers.

CRITICAL INCIDENTS

In 2016, Riverside County Children's Services had **162** critical incidents reported. These included; 113 child fatalities, 15 child near fatalities, 21 child "other" critical incidents, and 19 parent deaths.

2016 OVERALL CI DATA

TYPE OF CRITICAL INCIDENT	QTY
Child Fatality	113
Child Near Fatality	15
Other Child-Related Critical Incident	21
Adult/Parent-Related Critical Incident**	15
TOTAL CI REVIEWS	**162**

2015/2016 COMPARISON OF CI DATA

	2016	2015		%
CDRT/Child Fatality	113	82	↑	38%
Child Near Fatality*	15	7	↑	114%
Other Child-Related	21	21	=	0%
Adult/Parent-Related**	15	15	=	0%
TOTAL	**162**	**125**	↑	**30%**

CRITICAL INCIDENTS

Below is a breakdown of the investigations related to child fatalities and near fatalities.

CHILD FATALITIES	113	CHILD NEAR FATALITIES*	15
Critical Incidents	**113**	**Critical Incidents**	**13**
Investigated	86	Investigated	13
High Profile/Media[1]	17	High Profile/Media[1]	5
Non CWS Related[2]	6	Non CWS Related[2]	0
At Risk/Sibling Abuse[3]	1	At Risk/Sibling Abuse[3]	0
Substantiated Allegations[4]	***26***	***Substantiated Allegations[4]***	***6***
Caretaker Absence/Incapactity	1	Caretaker Absence/Incapactity	2
General Neglect	14	General Neglect	4
Severe Neglect	11	Severe Neglect	0
Existing Cases[5]	***4***	***Existing Cases[5]***	***0***
Family Reunification	1	Family Reunification	0
Permanent Placement	3	Permanent Placement	0

CRITICAL INCIDENTS

The referrals received by the Central Intake Center are forwarded to our unit (Continuous Quality Improvement/ Quality Assurance) to begin tracking for possible review.

If circumstances of the referral are due to child abuse/neglect, they will be reviewed by our unit once the referral is closed.

During the review, we look for:

- Practice strengths
- What we could improve on
- Next steps
- If previous history, what we may have missed?

A new process beginning for our unit is a feedback loop to the various regional offices to discuss the review. Trends that may be appearing within the specific region and/or agency.

CRITICAL INCIDENTS

CRITICAL INCIDENT FACE SHEET			
TYPE OF CI	**DATE OF CI**	**DATE OF CQI REVIEW**	**CQI REVIEWER**
			CQI Unit
REFERRAL INFORMATION			
REGION	**MOTHER'S NAME**		**CHILD'S NAME**
REFERRAL NUMBER	**REFERRAL DATE**	**REFERRAL TYPE**	**REFFERAL DISPOSITION**
		☐IR ☐10-day ☐EVO	
DPSS 3387	**DPSS 1872**	**MEDIA**	**RESIDENCE OF CHILD AT TIME OF CI**
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐Home of Parent/LG ☐Out-of-Home/FC
ALLEGATIONS (Primary – choose only one)			
☐General Neglect ☐Severe Neglect ☐Physical Abuse ☐Sexual Abuse ☐Emotional Abuse ☐Caretaker Absence/Incapacitated			
ALLEGATIONS (Secondary – choose all that apply)			
☐General Neglect ☐Severe Neglect ☐Physical Abuse ☐Sexual Abuse ☐Emotional Abuse ☐Caretaker Absence/Incapacitated			
DEPENDENCY AT TIME OF CI	**PREVIOUS DEPENDENCY FOR FAMILY**		**CASE OPENED AS A RESULT OF CI**
☐ YES ☐ NO	☐ YES ☐ NO		☐ YES ☐ NO
TIMELY CONTACT MADE	**CLOSED WITHIN 30 DAYS**		**SPECIAL CODE(S):**
☐ YES ☐ NO *IF NO, PROVIDE COMMENT:*	☐ YES ☐ NO *IF NO, PROVIDE COMMENT:*		☐CSEC ☐DEC ☐KWG ☐HX ALERT ☐TRAC
CHILD'S SIBLINGS /OTHER CHILDREN IN THE HOME			
☐ YES ☐ NO *IF YES, PROVIDE THE FOLLOWING INFORMATION ON THAT CHILD/REN:*			
NAME	**AGE**	**RELATIONSHIP TO CHILD**	**CURRENT PLACEMENT**
PRIOR REFERRAL(S) INFORMATION			
DATE	**ALLEGATION**	**DISPOSITION**	**COUNTY**
	Choose an item.	Choose an item.	
SUMMARY OF CRITICAL INCIDENT			

CRITICAL INCIDENTS

CQI FEEDBACK FORM

CASE NAME:	**DATE:**
Primary REGION:	**Case ID:**
Quarter:	

Safety

1. What is working well?

2. What are you worried about?

3. What needs to happen?

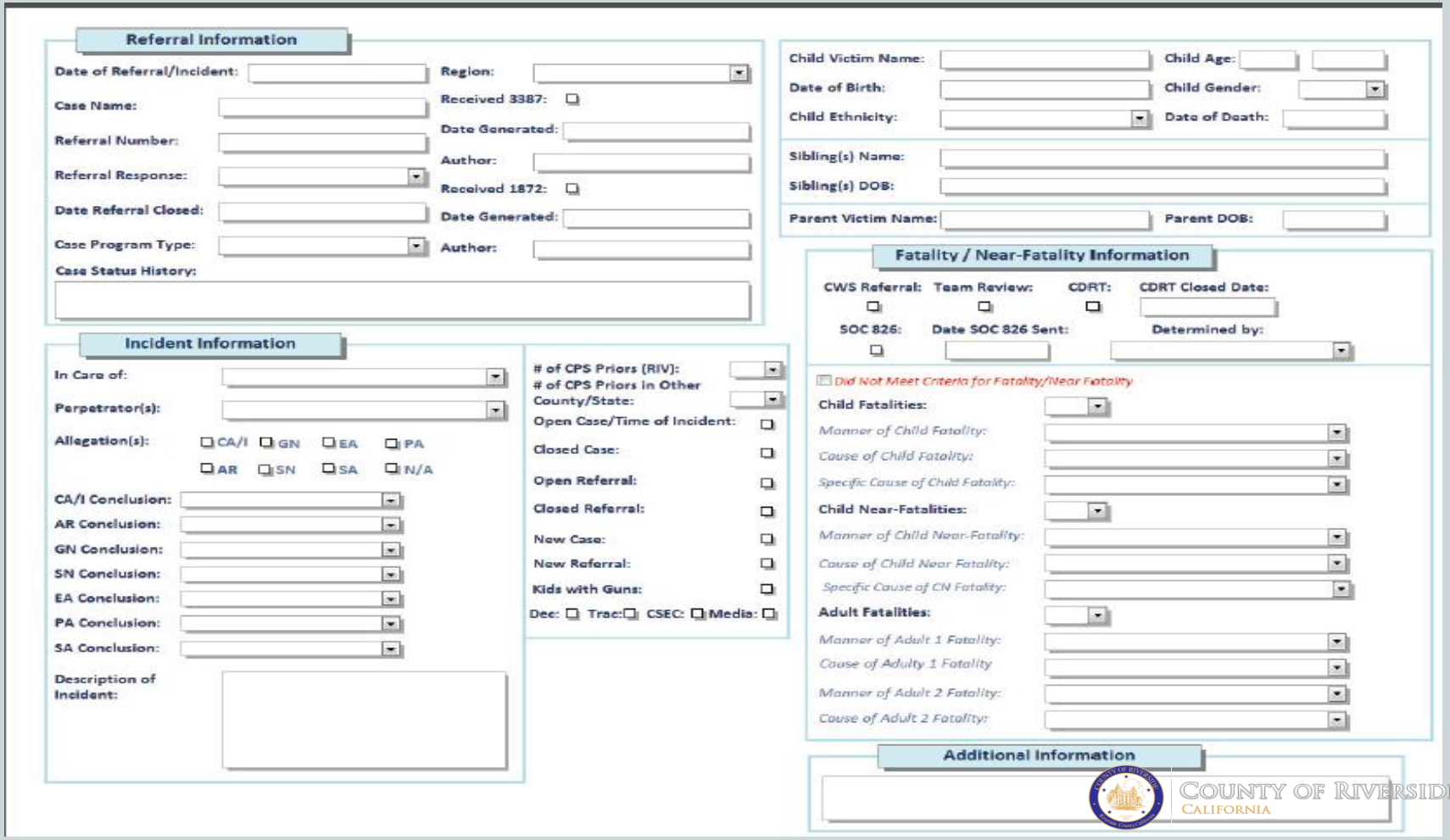
Permanency

1. What is working well?

CHILD DEATH REVIEW TEAM

Every Child Death that occurs in Riverside County is reviewed by the "Child Death Review Team," or CDRT. CDRT is a multidisciplinary team of Riverside County professionals who meet to share information and history known of the child/family before, during, or after the death. Members include representatives of the Sheriff-Coroner's Bureau (investigator, pathologist, and/or a forensic pediatrician), the District Attorney's Office, Children's Services, Health/Behavioral Health Services, and representatives of the law enforcement agency conducting the local investigation.

CHILD DEATH REVIEW TEAM



CHILD DEATH REVIEW TEAM

Child Fatalities accounted for 70% of the overall critical incident reviews conducted in 2016. Over the course of the year, there were 113 Child Fatalities in Riverside County that were reported to Children's Services, a 38% increase from 2015.

2016 OVERALL CDRT DATA

TYPE OF FATALITY	QTY
Natural	64
Accident	26
Suicide	9
Homicide	3
Undetermined	9
Pending	2
TOTAL CDRT CASE REVIEWS	**113**

CHILD DEATH REVIEW TEAM

The Continuous Quality Improvement Unit serves as a liaison to the Operational Regions when there are updates required for the SOC 826 for CDSS.

Example 1- Child Fatality-SIDS w/ Cocaine in infant's system

The referral meets the criteria for a SOC 826 Child Fatality/ Near Fatality County Statement of Findings and Information form to CDSS. CQI will complete and submit the SOC 826 to CDSS. Attached is a screen shot of the child's demographics page, fatality fields. Please be advised the following updates are required:

1) Change Death Circumstance Type to Confirmed Abuse.

2) As to Place of Death, enter Corona.

3) Enter the following into Death Circumstances Comments: "The Coroner determined the child's cause of death to be SIDS w/ Cocaine in the system."

CHILD DEATH REVIEW TEAM

Example 2- Child Fatality- Medical Neglect

The referral has been submitted for closure and the allegations of general neglect and severe neglect are substantiated. Thus, this meets the criteria for a SOC 826 Child Fatality/ Near Fatality form and QA will complete and submit the report to CDSS upon closure of the referral. Prior to closure, please ensure the deceased child's demographics page, child fatality fields are updated. Attached is a screenshot of the child's demographics page.

1) Currently, the deceased child's Death Circumstances Type is blank, please change to reflect Confirmed Abuse (as allegations were substantiated).

2) Additionally, as to Death Circumstance Comments, please include the information found in the Closing Summary, Rationale for Disposition.

3) Also, please enter the date of the child fatality.

CHILD DEATH REVIEW TEAM

Example 3-Near Fatality-Physical Abuse

The referral is identified as a near fatality caused by abuse or neglect, and as such warrants a SOC 826 Child Fatality/ Near Fatality County Statement of Findings and Information form to CDSS. The CQI unit will complete and submit the SOC 826. Per CDSS the following updates are required:

1) Near Fatality date in victim child's demographics tab is blank, please enter the date of the near fatality: 10/28/17

2) The child's near fatality condition should be documented in CWS/CMS in the delivered service log and the child's health passport in the hospitalization tab.

CHILD DEATH REVIEW TEAM

Example 4-Child Fatality at Day Care Provider's Home

The child died while in the care of the daycare provider. The referral was closed as inconclusive. During the course of the CDRT, the DA filed charges of Involuntary Manslaughter, thus meeting the criteria for a SOC 826 submission.

Please be advised the following updates are required:

1) Change Death Circumstance Type is Undetermined, please change to reflect Confirmed Abuse.

2) As to Place of Death, enter Riverside.

3) Enter the following into Death Circumstances Comments: "The child care provider, Jane Doe, was charged with PC 192 (B) Involuntary Manslaughter, Court Case # ABC123, Riverside police report # 171234."

CHILD DEATH REVIEW TEAM

The Child Death Review:

Strengths:

- Collaboration between Children's Services and outside agencies (ex. Coroner, Law Enforcement, DA, and CDSS).
- The Operational Regions are receptive when updates are required and have an interest in becoming further educated about child fatality/near fatality requirements.

Challenges:

- As to child fatalities/near fatalities there is a need to continuously provide education with regard to social work practice and CWS/CMS data entry.

THANK YOU!!

Riverside County Children's Services

Continuous Quality Improvement Unit

Robert Lough, CSSS II

rlough@rivco.org

Jennifer Strout, CSSS II

jstrout@rivco.org

Betty Tamtomo, PS II

btamtomo@rivco.org

NOTES FROM WEBINAR: BEST REPORTING PRACTICES BY COUNTY CWS AGENCIES

- Orange County presentation
  - Ilan Wolf
  - Identified the importance of their Administrative Division that includes Quality Assurance components for submitting the SOC 826 to the CDSS
  - Single Point of Contact for their Critical Incidents who conducts follows up with collaborating agencies or internal staff on determinations and to ensure consistent documentation is captured
  - Also utilize their county CDRT to have discussions regarding child fatalities and ensure CWS is aware of cases CDRT reviews
- Los Angeles County presentation
  - Francisco Torres
  - Identified the importance of their ESCARs system between CWS, the District Attorney & Sheriff's Department
  - All child fatalities are reported & CWS are able to view the status of Law Enforcement investigations and findings in addition to CWS investigative findings
- Riverside County presentation
  - Jennifer Strout
  - Robert Lough
  - Betty Tamtomo
  - *Power Point Materials included on previous slides*

SECTION 3
WEBINAR QUESTIONS & ANSWERS

- Q1: Does Orange County have a policy & procedure they can share with County Webinar participants?
- A: Orange County – Yes, most of our policies & procedures are online and we can send that link to the CDSS so that it may be shared.
  - Link enclosed: http://ssa.ocgov.com/about/policies/cfs_policies

- Q2: Does your CDRT have the authority to generate a referral for other children in the home following a child fatality?
- A: Orange County – yes, when CWS is in attendance at a CDRT meeting if concerning information is learned, CWS encourages CDRT members to call in a referral to ensure CWS is able to put the referral through the CWS Intake Emergency Response Protocol.
- A: Riverside County – yes, we encourage our mandated reporters to contact our CWS central intake hotline unit when there are concerns.
- A: Los Angeles County – yes same process for our county.
- A: CDSS – Review of Child Welfare Services Division 31 regulations re: if CWS learns about a fatality/near fatality where there is reasonable suspicion of abuse &/or neglect, the information should be reported and assessed through the Emergency Response Protocol.

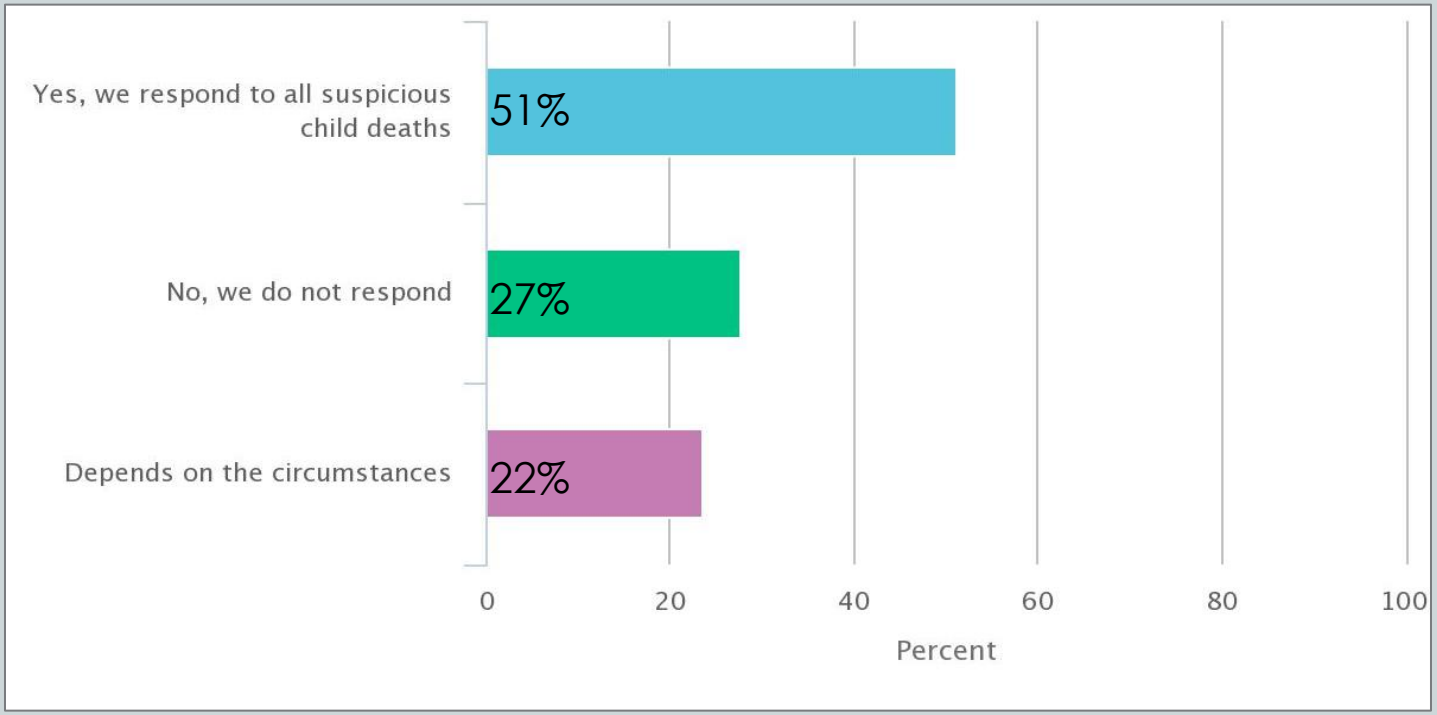
Section 4

August 2017 Webinar Poll Follow-up

QUESTION #4: DOES YOUR COUNTY RESPOND TO REPORTS OF A SUSPICIOUS CHILD DEATH WHEN IT IS REPORTED THAT THERE ARE NO OTHER CHILDREN IN THE HOME?

Responses:

- Yes, we respond to all suspicious child deaths
- No, we do not respond
- Depends on the circumstances



BEST PRACTICE

- CWS respond to all suspicious child death.
- Establish cross report protocol with local law enforcement and coroner to report all child deaths due to suspected abuse or neglect to CWS.
- Utilize CDRTs to learn of child's death determinations for reports that were not investigated by CWS.

CONCERNS

- Within the last 5-years, approximately 33.3% (138) of critical incidents reported to CDSS were evaluated-out due to no siblings in the home.

- A closer look into these cases revealed that some of these reports consist of surviving siblings where the alleged perpetrator no longer had access to them due to: death by suicide or incarceration.

CASE SAMPLE

- A murder suicide was reported to CWS from another CWS county. Father took child alone to car and mother contacted law enforcement when she became concerned.
- CWS was informed of surviving siblings and the concern that they may be at risk.
- CWS evaluated-out the report as not meeting penal code definition of abuse/neglect.

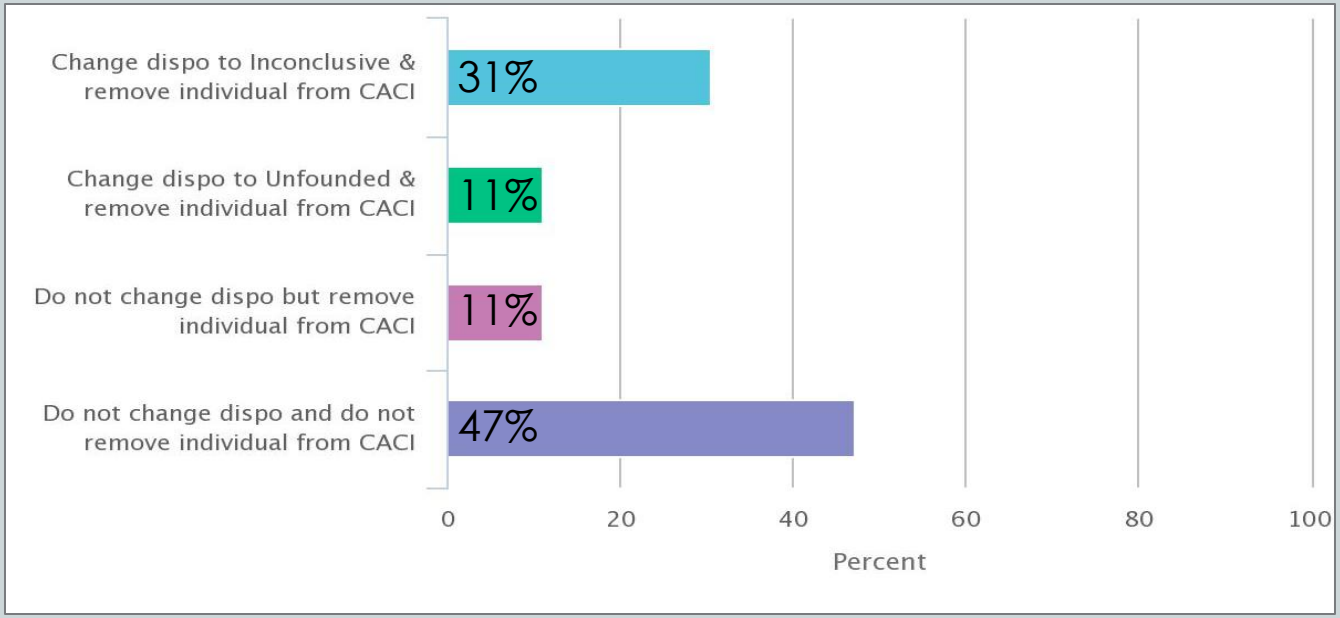
Additional information revealed:

- Mother reported Father had made threats of suicide prior to being left alone with child.
- Law Enforcement discovers the deceased Father and child.
- Toxicology report revealed father was positive for various substances.

QUESTION #5: FOLLOWING A DISPOSITION OF SUBSTANTIATED ABUSE, THE JUDGE DISMISSES THE PETITION AS NOT SUPPORTED BY EVIDENCE. DOES YOUR COUNTY:

Responses:

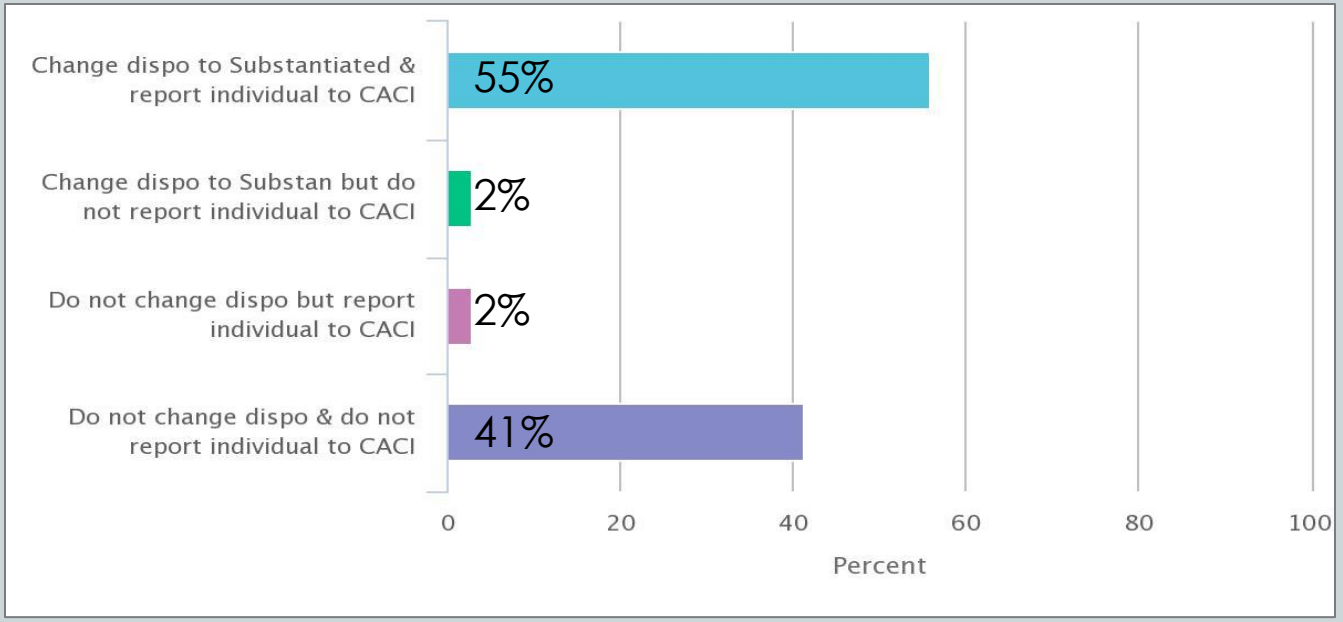
- Change disposition to Inconclusive & remove individual from CACI
- Change disposition to Unfounded & remove individual from CACI
- Do not change disposition but remove individual from CACI
- Do not change disposition and not remove individuals from CACI



QUESTION #6: FOLLOWING AN INCONCLUSIVE ABUSE ALLEGATION, THE COURT INVESTIGATION LEADS TO A SUSTAINED 'A' PETITION. DOES YOUR COUNTY:

Responses:

- Change disposition to Substantiated & report individual to CACI
- Change disposition to Substantiated but do not report individual to CACI
- Do not change disposition but report individual to CACI
- Do not change disposition & do not report individuals to CACI



BEST PRACTICE

- CWS to re-examine an investigation's allegation conclusion to match the court proceeding, specifically allegations related to child fatalities/near fatalities.

CONCERNS

- A victim child involved in a critical incident which has been determined to be due to child abuse and neglect has suffered a form of abuse reportable to CACI.

- Submitting agencies are responsible for maintaining the accuracy, completeness, and retention of reports to CACI.

CONCERNS
CONTINUED

- A complainant's CACI grievance hearing may be denied as a court of competent jurisdiction has determined that:
  - the suspected child abuse and/or severe neglect has occurred or
  - if a report which was previously filed was subsequently proved not to be substantiated
- CACI information may be used for temporary placement of a child in an emergency situation.
- CACI information may be used by licensed adoption agency for any person applying for adoption.

CASE SCENARIO

- A judge may dismiss an “A” allegation and sustain a “B” allegation where the child suffered serious physical harm or illness.
- A judge dismisses a critical incident as not true and the victim child or surviving siblings are returned to the parents or protective custody is dismissed.

REFERENCES

- PC 11169
- Division 31-021

For more information regarding CACI grievance process:
Amanda.Ferreira@dss.ca.gov
(916) 651-8982

Child Welfare Policy & Program Development Bureau
(916) 651-6160 main line

NOTES FROM WEBINAR: AUGUST 2017 WEBINAR POLL FOLLOW-UP

- Cindy Yang – Analyst from the Critical Incident Oversight & Support unit presented
- Reviewed the poll results of the August 2017 County Webinar - identified concerns & best practice recommendations
  - Review of a Child Fatality evaluated out referral case sample
  - Discussion of the importance of correct information within CACI so that it may be utilized as a tool to protect the health & safety of California's children
  - Review of Case Scenarios needing reexamination of an allegation conclusion based upon court findings may be needed
    - If allegation conclusions need to be changed/updated – Please refer to August 2017 County Webinar meeting materials.

SECTION 4
WEBINAR QUESTIONS & ANSWERS

- Q1: If CWS has a Physical Abuse allegation that is substantiated but the court does not make the same findings and settles for a lesser allegation of Neglect, would we still report the Physical Abuse to CACI?
- A: Potentially. If the lesser allegation meets the penal code definition of physical abuse or severe neglect, that would be reported to CACI. The CDSS provided technical support guidance regarding this on a previous county webinar.
- Q2: Our county had a case where we substantiated Physical Abuse but the court dismissed it, would we still change the disposition and update CACI?
- A: CDSS recommendation would be to remove the Physical Abuse from CACI and ensure that the court findings and CWS/CMS be consistently documented. Further, the Penal code requires the county child welfare agency to ensure the accuracy of CACI and the reports submitted to CACI.

Thank you for your participation!

There will be a short three question survey following the end of the webinar

Email for Technical Assistance:

ChildFatality@dss.ca.gov

Critical Incident Oversight & Support Website:

http://www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality

Meeting materials may be found on our Resources & FAQs page